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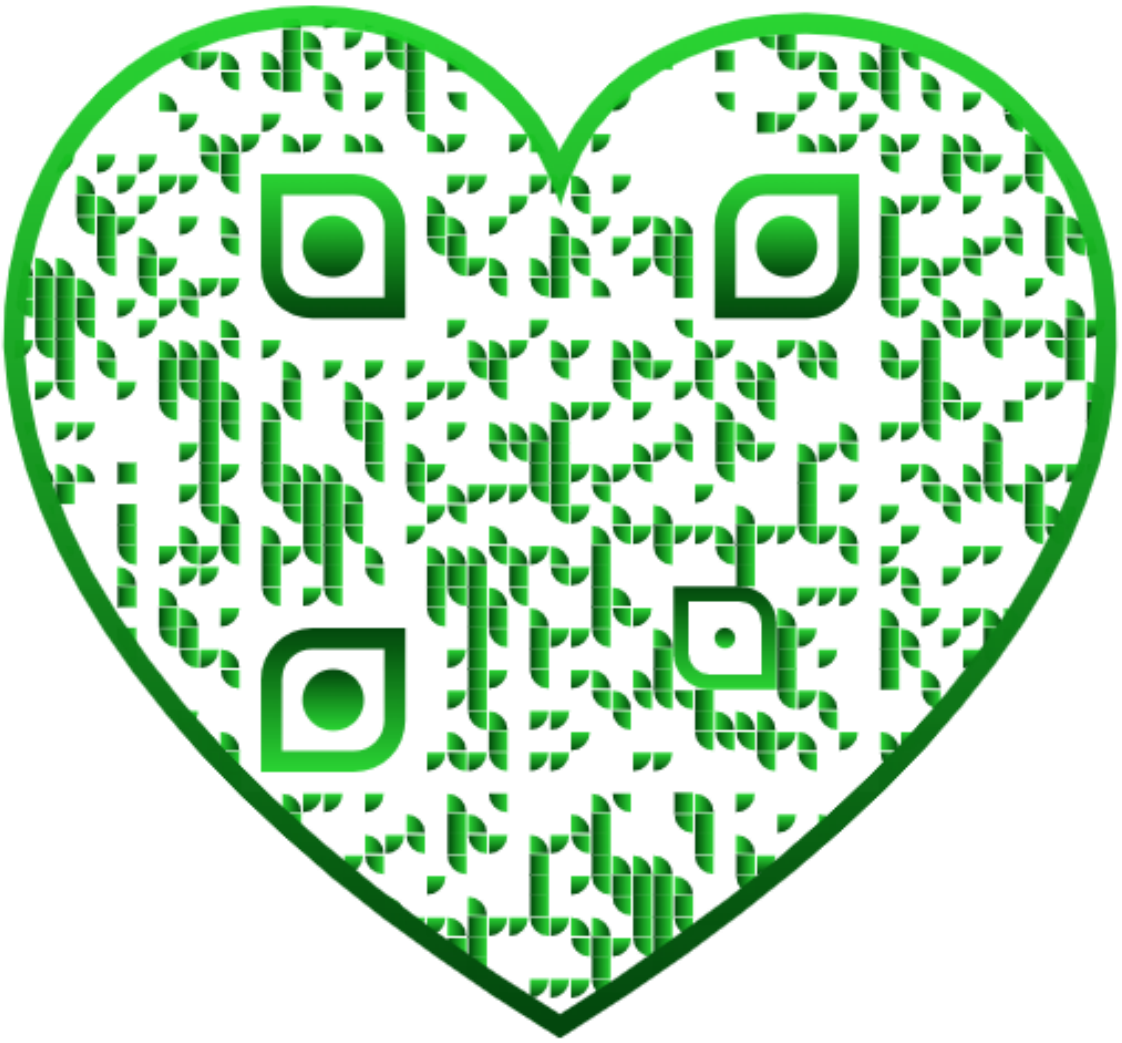
2026 Guideline for the Early Management of Patients with Acute Ischemic Stroke

Key Nursing Updates and Review from the Nursing Perspective



SLIDE SET DEVELOPED BY

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on behalf of the
STROKE SCILL/Professional
Education Committee

This document includes select AI-assisted imagery created by our designers.

PURPOSE STATEMENT

This presentation highlights key recommendations from the *2026 Guideline for the Early Management of Patients with Acute Ischemic Stroke* that are particularly relevant to nursing practice and can be used by individual organizations to standardize clinical practice for the care of acute ischemic stroke. Nurses are integral in developing congruent, evidence-based systems of care for stroke patients across care settings. While the entire guideline informs quality care delivery, nurses are uniquely positioned to identify, monitor, and respond to specific clinical situations that directly impact patient outcomes on a daily basis.

The topics presented here reflect the clinical decisions and assessments that nurses routinely encounter during their shifts—from recognizing early warning signs and implementing preventive measures to collaborating with the interdisciplinary team and advocating for patient safety. This slide includes neuroscience nursing clinical practice care assessments specific to the acute stroke population, emphasizing those points of care where nursing knowledge, vigilance, and clinical judgment make a tangible difference in patient recovery and well-being.

By focusing on these specific areas, we aim to strengthen nurses' understanding of evidence-based practices that support organizational efforts to standardize stroke care and empower nurses to deliver the highest standard of care in their everyday practice.

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CLASS (STRENGTH) OF RECOMMENDATION (COR) AND LEVEL (QUALITY) OF EVIDENCE (LOE)

COR: The **C**lass **o**f **R**ecommendation indicates the ***strength*** of a recommendation, based on the benefits of a treatment weighed against its risks. It's essentially a grade for what a clinician should do.

LOE: The **L**evel **o**f **E**vidence explains the ***quality*** of the scientific research that supports the recommendation. It tells you how confident the experts are in the data behind the recommendation.

CLASS (STRENGTH) OF RECOMMENDATION

CLASS 1 (STRONG) — **Benefit >>> Risk**

Suggested phrases for writing recommendations:
- Is recommended
- Is indicated/useful/effective/beneficial
- Should be performed/administered/other
- Comparative-Effectiveness Phrases†:
  - Treatment/strategy A is recommended/indicated in preference to treatment B
  - Treatment A should be chosen over treatment B

CLASS 2a (MODERATE) — **Benefit >> Risk**

Suggested phrases for writing recommendations:
- Is reasonable
- Can be useful/effective/beneficial
- Comparative-Effectiveness Phrases†:
  - Treatment/strategy A is probably recommended/indicated in preference to treatment B
  - It is reasonable to choose treatment A over treatment B

CLASS 2b (Weak) — **Benefit ≥ Risk**

Suggested phrases for writing recommendations:
- May/might be reasonable
- May/might be considered
- Usefulness/effectiveness is unknown/unclear/uncertain or not well-established

CLASS 3: No Benefit (MODERATE) — **Benefit = Risk**

Suggested phrases for writing recommendations:
- Is not recommended
- Is not indicated/useful/effective/beneficial
- Should not be performed/administered/other

CLASS 3: Harm (STRONG) — **Risk > Benefit**

Suggested phrases for writing recommendations:
- Potentially harmful
- Causes harm
- Associated with excess morbidity/mortality
- Should not be performed/administered/other

LEVEL (QUALITY) OF EVIDENCE‡

LEVEL A
- High-quality evidence‡ from more than 1 RCT
- Meta-analyses of high-quality RCTs
- One or more RCTs corroborated by high-quality registry studies

LEVEL B-R (Randomized)
- Moderate-quality evidence‡ from 1 or more RCTs
- Meta-analyses of moderate-quality RCTs

LEVEL B-NR (Nonrandomized)
- Moderate-quality evidence‡ from 1 or more well-designed, well-executed nonrandomized studies, observational studies, or registry studies
- Meta-analyses of such studies

LEVEL C-LD (Limited Data)
- Randomized or nonrandomized observational or registry studies with limitations of design or execution
- Meta-analyses of such studies
- Physiological or mechanistic studies in human subjects

LEVEL C-EO (Expert Opinion)
- Consensus of expert opinion based on clinical experience.

COR and LOE are determined independently (any COR may be paired with any LOE).

A recommendation with LOE C does not imply that the recommendation is weak. Many important clinical questions addressed in guidelines do not lend themselves to clinical trials. Although RCTs are unavailable, there may be a very clear clinical consensus that a particular test or therapy is useful or effective.

* The outcome or result of the intervention should be specified (an improved clinical outcome or increased diagnostic accuracy or incremental prognostic information).

† For comparative-effectiveness recommendation (COR 1 and 2a; LOE A and B only), studies that support the use of comparator verbs should involve direct comparisons of the treatments or strategies being evaluated.

‡ The method of assessing quality is evolving, including the application of standardized, widely-used, and preferably validated evidence grading tools; and for systematic reviews, the incorporation of an Evidence Review Committee.

COR indicates Class of Recommendation; EO, expert opinion; LD, limited data; LOE, Level of Evidence; NR, nonrandomized; R, randomized; and RCT, randomized controlled trial.

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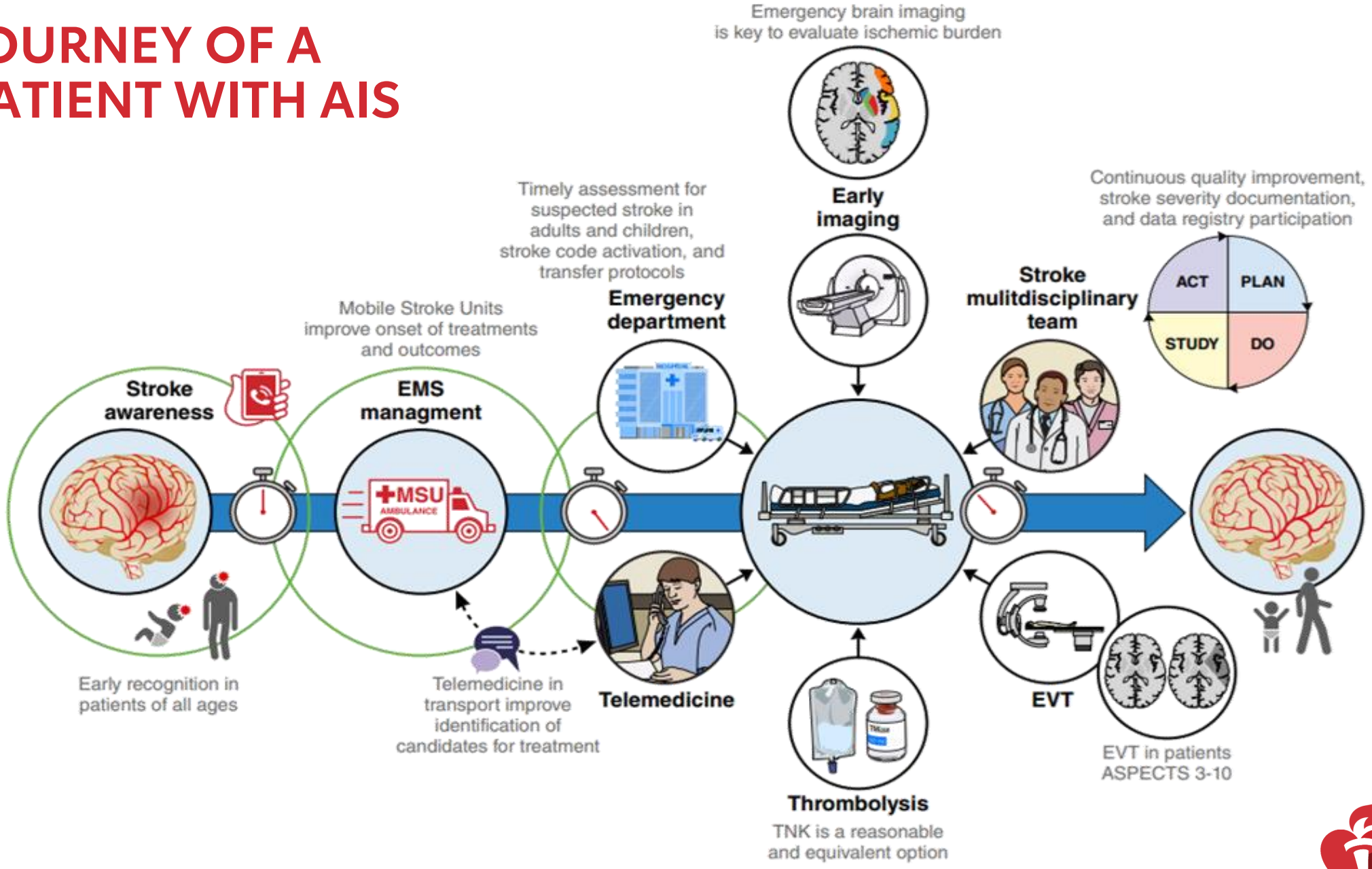
JOURNEY OF A PATIENT WITH AIS


Emergency brain imaging is key to evaluate ischemic burden
Early imaging
Timely assessment for suspected stroke in adults and children, stroke code activation, and transfer protocols
Emergency department
Mobile Stroke Units improve onset of treatments and outcomes
Continuous quality improvement, stroke severity documentation, and data registry participation
Stroke mulitdisciplinary team
ACT
PLAN
STUDY
DO
Stroke awareness
EMS managment
MSU
AMBULANCE
Early recognition in patients of all ages
Telemedicine in transport improve identification of candidates for treatment
Telemedicine
EVT
EVT in patients ASPECTS 3-10
Thrombolysis
TNK is a reasonable and equivalent option

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KEY NURSING TOPICS FOR REVIEW

From the 2026 Guideline for the Early Management of Patients with Acute Ischemic Stroke

Recommendation Categories	Topics for Review
Pediatric	General Summary of Updates
Prehospital	EMS Destination Management , Mobile Stroke Units, Interhospital Transfers
Acute Treatment	Thrombolysis and Management Review, Wake Up and 4.5 – 9 hour strokes, Telestroke and Thrombolysis, BP Management after Acute Treatments, Basilar EVT
Post Acute	Dual Antiplatelets for Minor AIS and High-Risk TIA, Early Anticoagulation and AF, Head Positioning, Brain Swelling,
General Supportive Care	Blood Glucose Monitoring, Depression, Nutrition, Dysphagia, Early Mobilization, Palliative Care, Multidisciplinary Management

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2026 GUIDELINE FOR THE EARLY MANAGEMENT OF PATIENTS WITH AIS

KEY NURSING UPDATES AND REVIEW

Pediatric Recommendations

PEDIATRICS – GENERAL SUMMARY

- More research is needed on tools to identify pediatric stroke in the EMS setting. (COR: 2b; LOE: B-NR)
- Nursing should facilitate **rapid imaging** on all suspected pediatric AIS patients utilizing an MRI/MRA of the brain if it can be performed in 25 minutes, or a CT/CTA, in order to diagnose LVO, hemorrhagic stroke, or other stroke mimics. (COR: 2a; LOE: C-LD)
- Alteplase **(tPA) may be considered** by the provider to treat pediatric ischemic stroke within 4.5 hours of onset, but efficacy is unknown. (COR: 2b; LOE: C-LD)
- If experienced pediatric neurointerventionalists are available:
  - for patients **≥ 6 years** of age, and an LVO confirmed **within 6 hours** of symptom onset, **EVT is reasonable** to consider and can be effective to improve functional outcomes. (COR: 2a; LOE: B-NR)
  - for patients **≥ 6 years** of age, and an LVO confirmed **between 6 – 24 hours** of symptom onset, with imaging that suggests potentially salvageable brain, **EVT is reasonable** to consider and can be effective to improve functional outcomes. (COR: 2a; LOE: B-NR)
  - for patients aged **28 days to 6 years**, and an LVO confirmed **within 24 hours**, with imaging that suggests potentially salvageable brain, **EVT may be reasonable** to consider to improve functional outcomes. (COR: 2b; LOE: B-NR)

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2026 GUIDELINE FOR THE EARLY MANAGEMENT OF PATIENTS WITH AIS

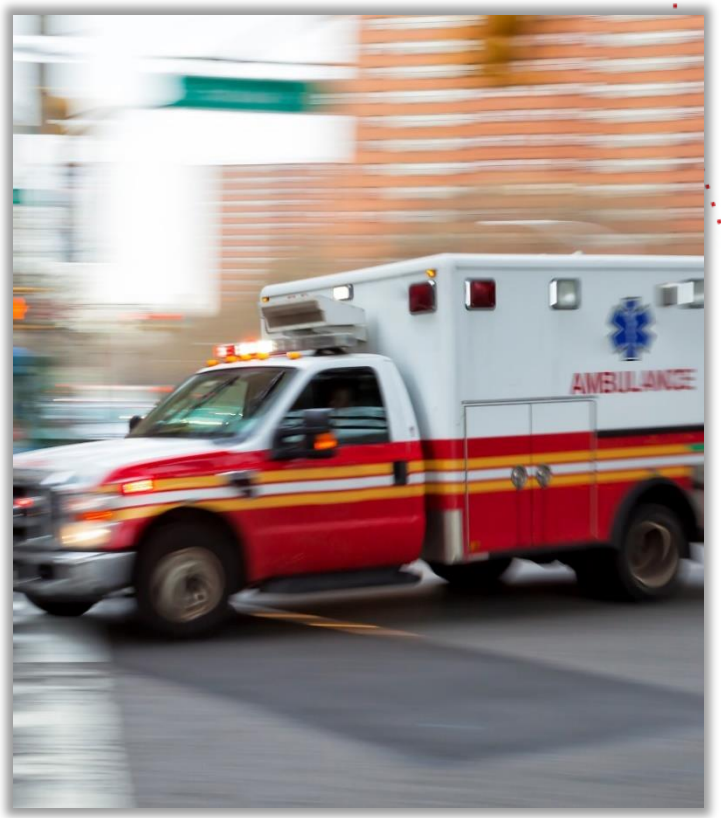
KEY NURSING UPDATES AND REVIEW

Prehospital Recommendations

EMS DESTINATION MANAGEMENT

Section	COR	LOE	RECOMMENDATIONS
2.4	1	B-NR	In patients with suspected acute stroke, EMS professionals should prioritize transport to the closest appropriate facility (acute stroke-ready hospital [ASRH], primary stroke center [PSC], thrombectomy-capable stroke center [TSC], or comprehensive stroke center [CSC]) to reduce time to treatment compared with transport to a nonstroke capable hospital.

Section	COR	LOE	RECOMMENDATIONS
2.4	3 No Benefit	B-R	In areas with well-coordinated SSOC and local hospital(s) proficient in thrombolysis delivery and secondary interhospital transfer, direct transport of patients with suspected LVO to a distant (eg, 45-60 min) TSC compared with transport to a local stroke center does not improve 3-month clinical outcomes.



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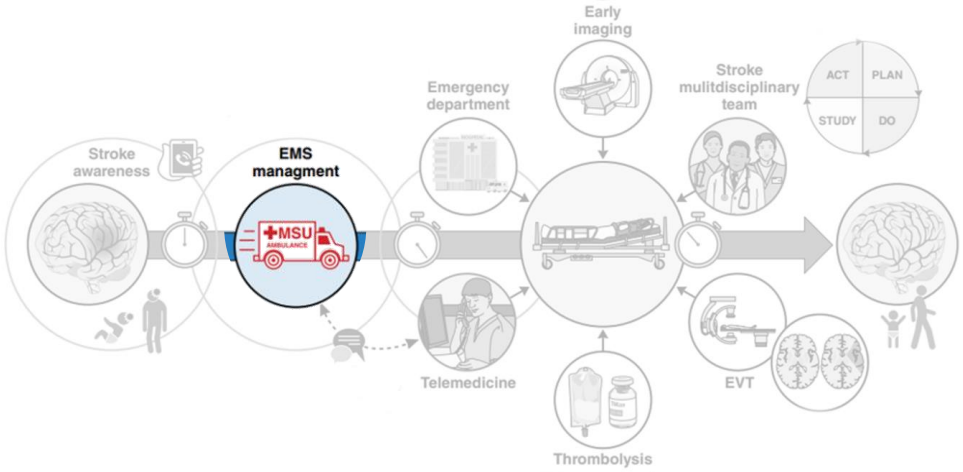
EMS – AREAS WITH MOBILE STROKE UNITS (MSU)



Interior pictures of regular-sized and large mobile stroke units displaying their essential components. Navi, B. B, et al. (2022). Mobile Stroke Units: Evidence, Gaps, and Next Steps. Stroke, 53(6). https://doi.org/10.1161/strokeaha.121.037376

Section	COR	LOE	RECOMMENDATIONS
2.4	1	A	In patients with suspected AIS, the use of MSUs over conventional EMS where available is recommended for the transport and management of thrombolytic-eligible patients to ensure the fastest achievable onset-to-treatment time and improve functional outcomes.

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INTERHOSPITAL TRANSFERS

Section	COR	LOE	RECOMMENDATIONS
2.4	1	B-NR	Hospitals and EMS professionals should establish agreements and protocols to prioritize interhospital transfer of patients with acute stroke needing a higher level of care to reduce door-in-door-out (DIDO) times.

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2026 GUIDELINE FOR THE EARLY MANAGEMENT OF PATIENTS WITH AIS

KEY NURSING UPDATES AND REVIEW

Acute Treatment Recommendations

ADULT THROMBOLYSIS

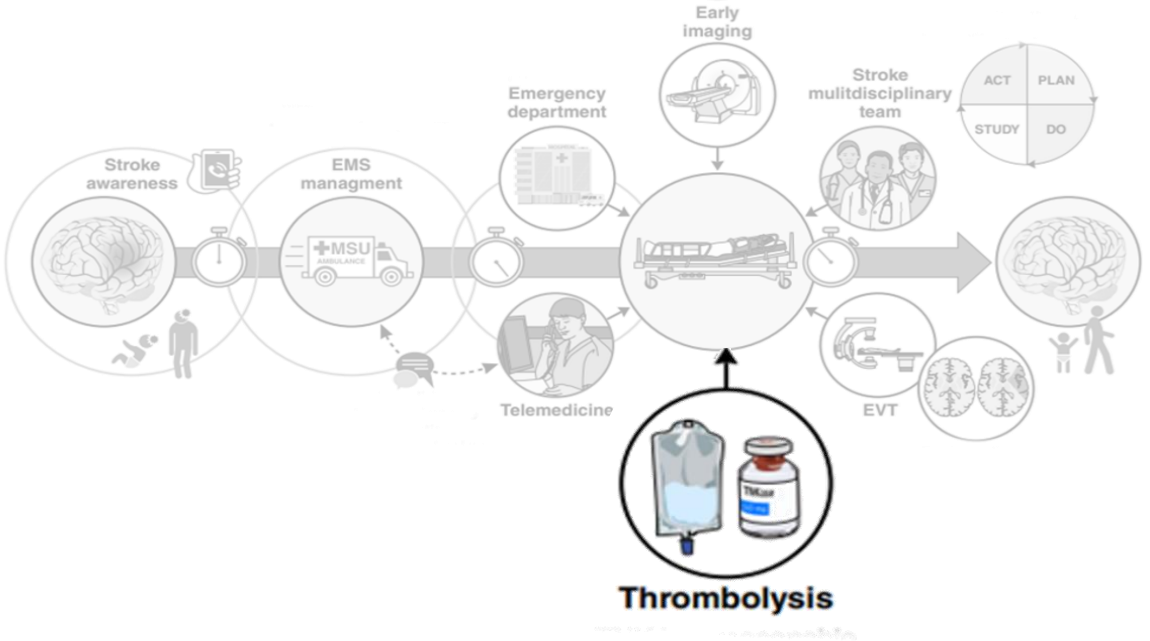
Tenecteplase (TNK) versus Alteplase (tPA)

In adult patients with AIS presenting **within 4.5 hours** of symptom onset or LKW and eligible for IVT either of the following is recommended to improve functional outcomes:

- TNK at a dose of 0.25 mg/kg body weight (max 25 mg) as a single 5-10 second IV bolus.

- or -

- tPA at a dose of 0.9 mg/kg body weight (max 90 mg) 10% given as an initial IV bolus and the remaining dose infused IV over 60 minutes



Section	COR	LOE	RECOMMENDATIONS
4.6.2	1	A	In adult patients with AIS presenting within 4.5 hours of symptom onset or last known well and eligible for IVT, tenecteplase at a dose of 0.25 mg/kg body weight (max 25 mg) or alteplase at a dose of 0.9 mg/kg body weight is recommended to improve functional outcomes.

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ADULT THROMBOLYSIS – NURSING REVIEW

Thrombolysis Dosing and Care

tPA/Alteplase Dosing: →

TNK/Tenecteplase dosing based on a sliding scale weight-based dosing table

Anticipated nursing orders post thrombolytics

Table 7. Treatment of AIS in Adults*: IVT

Alteplase: Infuse 0.9 mg/kg (maximum dose 90 mg) over 60 min, with 10% of the dose given as a bolus over 1 min		
Tenecteplase: Push 0.25 mg/kg (up to maximum 25 mg) based on patient body weight†:		
Patient weight (kg)	**TNK (mg)**	**Volume TNK to be administered (mL)**
<60 kg	15	3
60 kg to <70 kg	17.5	3.5
70 kg to <80 kg	20	4
80 kg to <90 kg	22.5	4.5
≥90 kg	25	5
Admit the patient to an intensive care or stroke unit for monitoring		
If the patient develops severe headache, acute hypertension, nausea, or vomiting or has a worsening neurological examination, discontinue the infusion (if IV alteplase is being administered) and obtain an emergency head CT scan.		
Measure BP and perform neurological assessments every 15 min during and after IVT administration for 2 h, then every 30 min for 6 h, then hourly until 24 h after IV alteplase treatment		
Increase the frequency of BP measurements if SBP is >180 mm Hg or if DBP is >105 mm Hg; administer antihypertensive medications to maintain BP at or below these levels		
Delay placement of nasogastric tubes, indwelling bladder catheters, or intraarterial pressure catheters if the patient can be safely managed without them		
Obtain a follow-up CT or MRI scan at 24 h after IVT before starting anticoagulants or antiplatelet agents		
*Dosing for pediatric patients has not been determined. † If <50kg and accurate weight is known, dosing per 1-kg band may be used. Do not delay thrombolysis to obtain exact weight – timely treatment is critical. With estimated weights, dosing per 1-kg band is not necessarily safer than 10-kg band dosing.		

AIS indicates acute ischemic stroke; BP, blood pressure; CT, computed tomography; DBP, diastolic blood pressure; IV, intravenous; IVT, intravenous thrombolysis; MRI, magnetic resonance imaging; and SBP, systolic blood pressure.

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ADULT THROMBOLYSIS – NURSING REVIEW

Symptomatic intracranial hemorrhage (SICH)

Post thrombolysis symptomatic intracerebral hemorrhage.
Gaillard F, Hemorrhagic transformation of MCA infarct. Case study, Radiopaedia.org; https://doi.org/10.53347/rID-23522

Table 5. Management of Symptomatic Intracranial Bleeding Occurring Within 24 Hours After Administration of IV Alteplase or Tenecteplase for Treatment of AIS in Adults

Stop alteplase infusion or tenecteplase (if still being pushed)
Emergent CBC, PT (INR), aPTT, fibrinogen level, and type and cross-match
Emergent nonenhanced head CT if a clinical concern exists
Cryoprecipitate (includes factor VIII): 10 U infused over 10–30 min to maintain fibrinogen level of ≥150 mg/dL; as a rule of thumb 10 U of cryoprecipitate increase fibrinogen level by nearly 50 mg/dL)
Tranexamic acid 1000 mg IV infused over 10 min OR e-aminocaproic acid 4–5 g over 1 h, followed by 1 g IV until bleeding is controlled (peak onset in 3 h) Potential for benefit in all patients, but particularly when blood products are contraindicated by patient/family or if cryoprecipitate is not available in a timely manner
Hematology and neurosurgery consultations as necessary
Supportive therapy, including BP management, ICP, CPP, MAP, temperature, and glucose control

Adapted with permission from Sloan et al,[4] Mahaffey et al,[5] Goldstein et al,[6] French et al,[7] Yaghi et al,[8–10] Stone et al,[11] and Frontera et al.[12]

AIS indicates acute ischemic stroke; aPTT, activated partial thromboplastin time; BP, blood pressure; CBC, complete blood count; COR, class of recommendation; CPP, cerebral perfusion pressure; CT, computed tomography; ICP, intracranial pressure; INR, international normalized ratio; IV, intravenous; LOE, level of evidence; MAP, mean arterial pressure; and PT, prothrombin time.

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THROMBOLYSIS – NURSING REVIEW

Orolingual Angioedema Management

Chaucer B, Whelan D, Veys C, Upadhyaya M. Angioedema secondary to IV tissue plasminogen activator administration for treatment of acute ischemic stroke. *Case Rep Crit Care*. 2018;2018:3257215. doi: 10.1155/2018/3257215

Table 6. Management of Orolingual Angioedema Associated With IV Thrombolytic Administration for AIS in Adults[53,54]

Maintain Airway
Endotracheal intubation may not be necessary if edema is limited to the anterior tongue and lips.
Edema involving the larynx, palate, floor of mouth, or oropharynx with rapid progression (within 30 min) poses a higher risk of requiring intubation.
Awake fiberoptic intubation is optimal. Nasal-tracheal intubation may be required but poses risk of epistaxis after IV thrombolytic use. Cricothyroidotomy is rarely needed and also problematic after IV thrombolytic use.
Discontinue IV thrombolytic infusion (if alteplase) and hold ACE inhibitors.
Administer IV methylprednisolone 125 mg.
Administer IV diphenhydramine 50 mg.
Administer ranitidine 50 mg IV or famotidine 20 mg IV.
If there is further increase in angioedema, administer 0.1% epinephrine (1 mg/mL concentration) 0.3 mL subcutaneously or by nebulizer 0.5 mg/dL.
Icatibant, a selective bradykinin B2 receptor antagonist, 3 mL (30 mg) subcutaneously in abdominal area; additional injection of 30 mg may be administered at intervals of 6 h not to exceed a total of 3 injections in 24 h; and plasma-derived C1 esterase inhibitor (20 IU/kg) has been successfully used in hereditary angioedema and ACE inhibitor-related angioedema.
Provide supportive care.

Adapted with permission from Sloan et al,[4] Mahaffey et al,[5] Goldstein et al,[6] French et al,[7] Yaghi et al,[8–10] Stone et al,[11] and Frontera et al.[12]

ACE indicates angiotensin-converting enzyme; AIS, acute ischemic stroke; COR, class of recommendation; IV, intravenous; and LOE, level of evidence.

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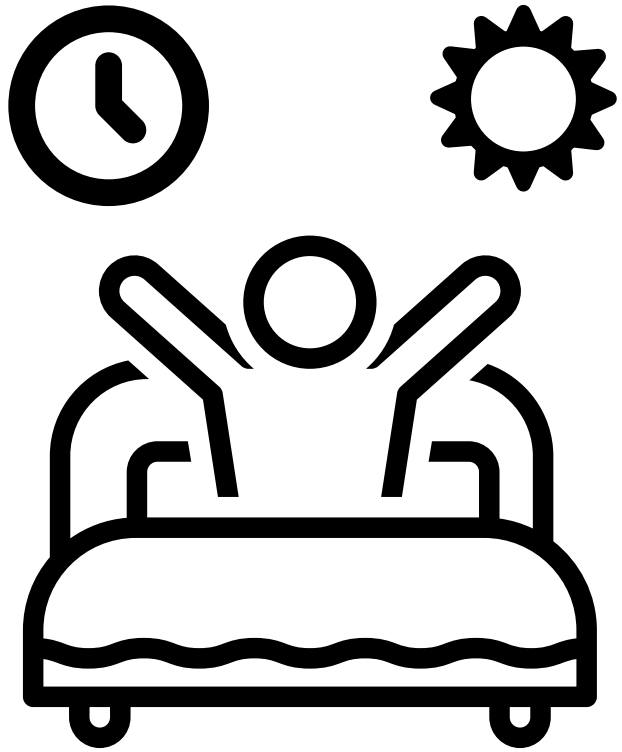
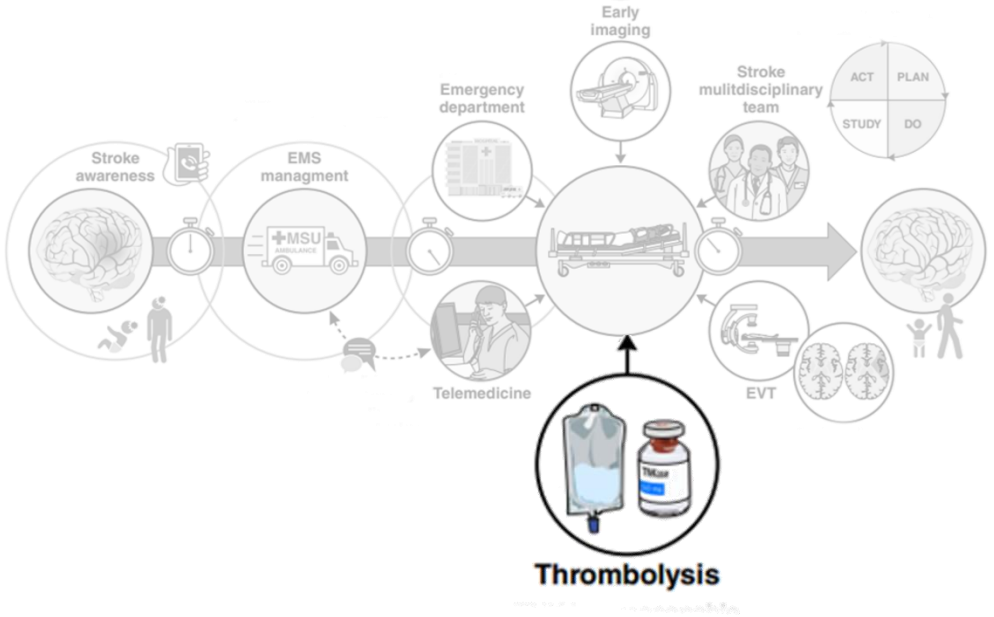
ADULT THROMBOLYSIS





Section	COR	LOE	RECOMMENDATIONS
4.6.3	2a	B-R	In patients with AIS who have salvageable ischemic penumbra detected on automated perfusion imaging and who (a) awake with stroke symptoms within 9 hours from the midpoint of sleep or (b) are 4.5-9 hours from last known well, IV thrombolysis may be reasonable to improve functional outcomes.

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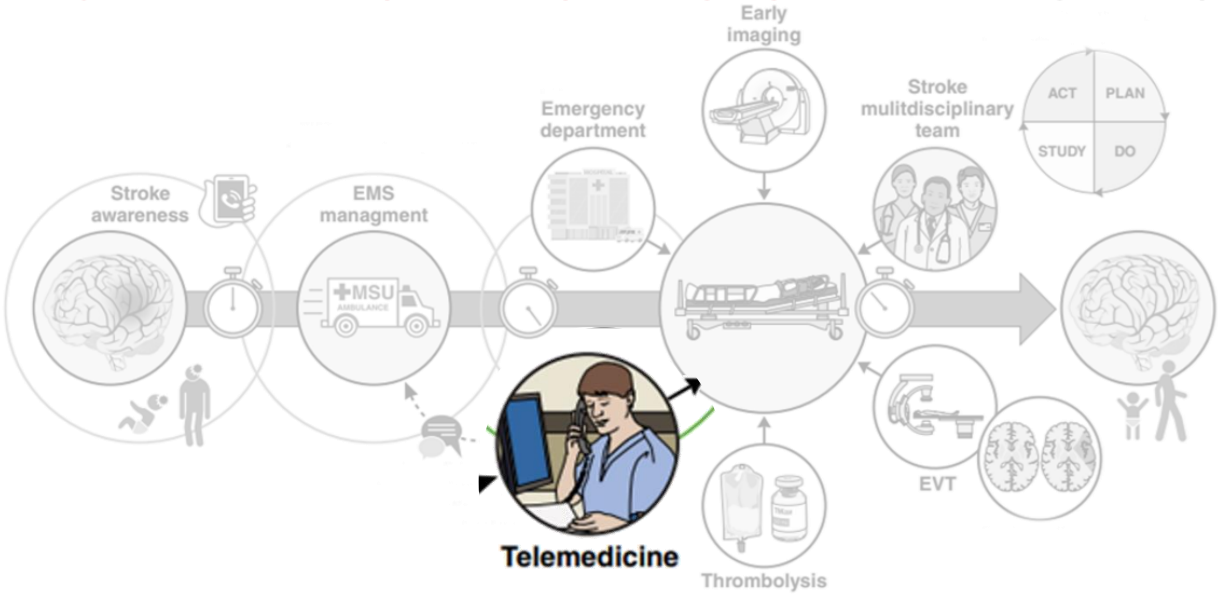
ADULT THROMBOLYSIS – TELESTROKE



Section	COR	LOE	RECOMMENDATIONS
2.4	1	B-R	For patients with suspected stroke in the prehospital setting, telemedicine in the ambulance should be considered, when feasible, to complement paramedic assessment to identify candidates for reperfusion interventions.

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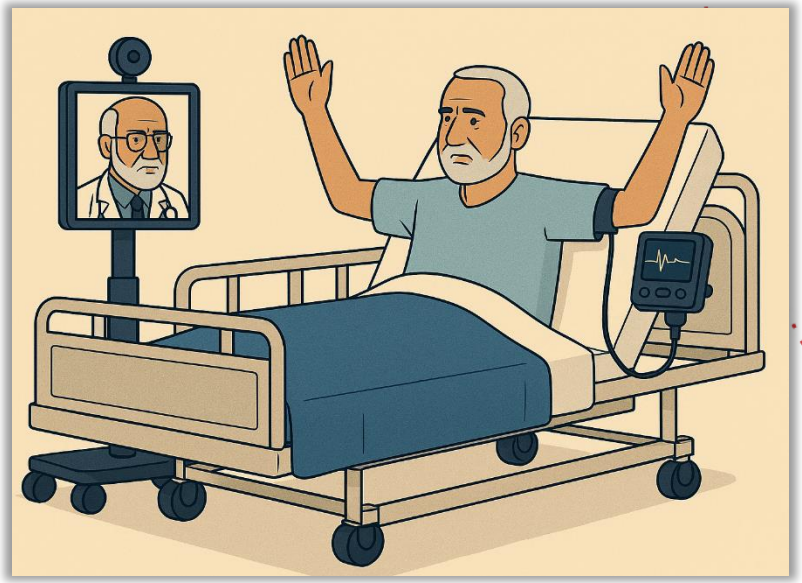
ADULT THROMBOLYSIS – TELESTROKE

Section	COR	LOE	RECOMMENDATIONS
2.8	1	B-R	For patients with AIS presenting to EDs without acute neurological expertise, telestroke systems are effective over usual care by the ED team for IVT decision-making and optimal thrombolytic delivery including increased thrombolytic administration and shorter time to delivery.
2.8	2a	B-NR	For patients with AIS treated at hospitals without local stroke expertise, telestroke is reasonable to reduce short-term mortality.
2.8	2a	C-LD	For patients with AIS treated at hospitals without in-house stroke expertise or telestroke capabilities, decision-making support by telephone consultation with a stroke specialist can be beneficial for IVT decision-making and consideration of EVT eligibility.



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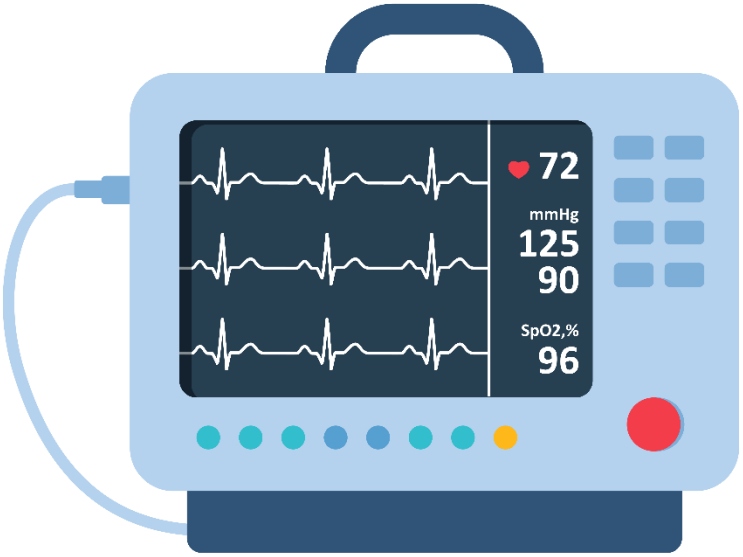
ADULT – BLOOD PRESSURE MANAGEMENT AFTER ACUTE TREATMENTS

Section	COR	LOE	RECOMMENDATIONS
4.3	1	B-R	BP should be maintained at <180/105 mm Hg for at least the first 24 hours after IVT treatment.
4.3	3 No Benefit	B-R	In patients with mild to moderate severity AIS who have been treated with IVT, intensive SBP reduction (target of <140 mm Hg compared with <180 mm Hg) is not recommended because it is not associated with an improvement in functional outcome.



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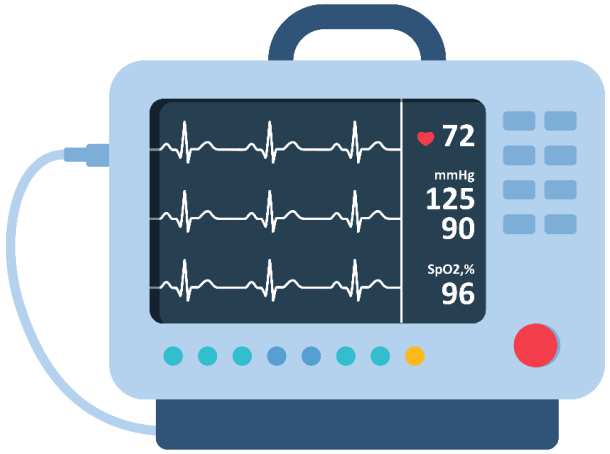
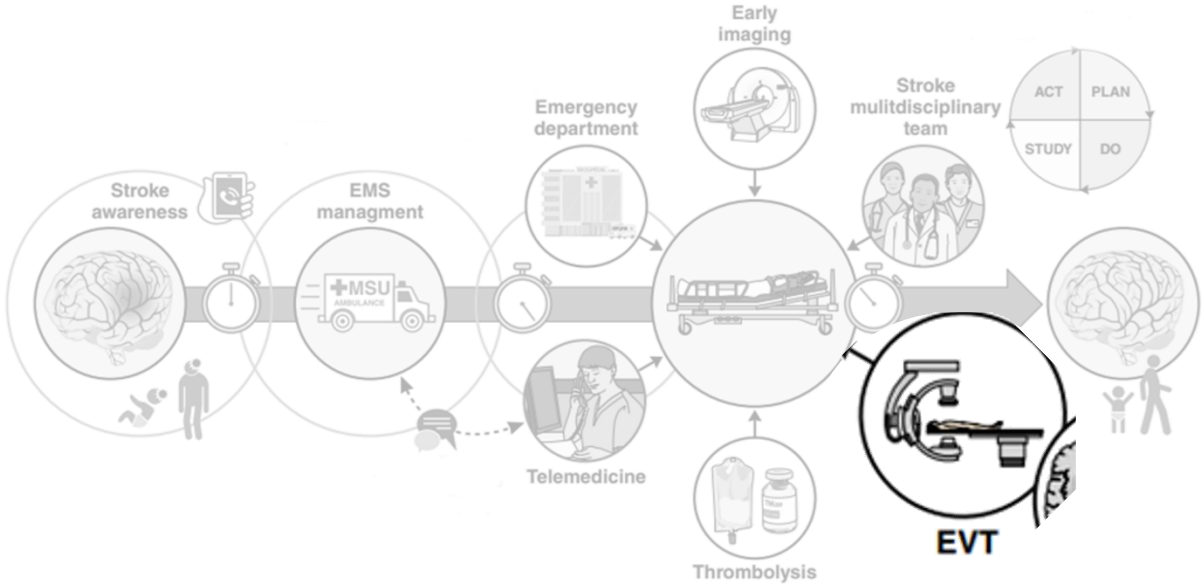
ADULT – BLOOD PRESSURE MANAGEMENT AFTER ACUTE TREATMENTS





Section	COR	LOE	RECOMMENDATIONS
4.3	3 Harm	A	In patients with AIS with LVO of the anterior circulation who have been successfully recanalized by endovascular therapy (mTICI 2b, 2c, or 3) and without other indication for blood pressure management target, intensive SBP reduction target of <140 mm Hg for the first 72 hours is harmful and not recommended.

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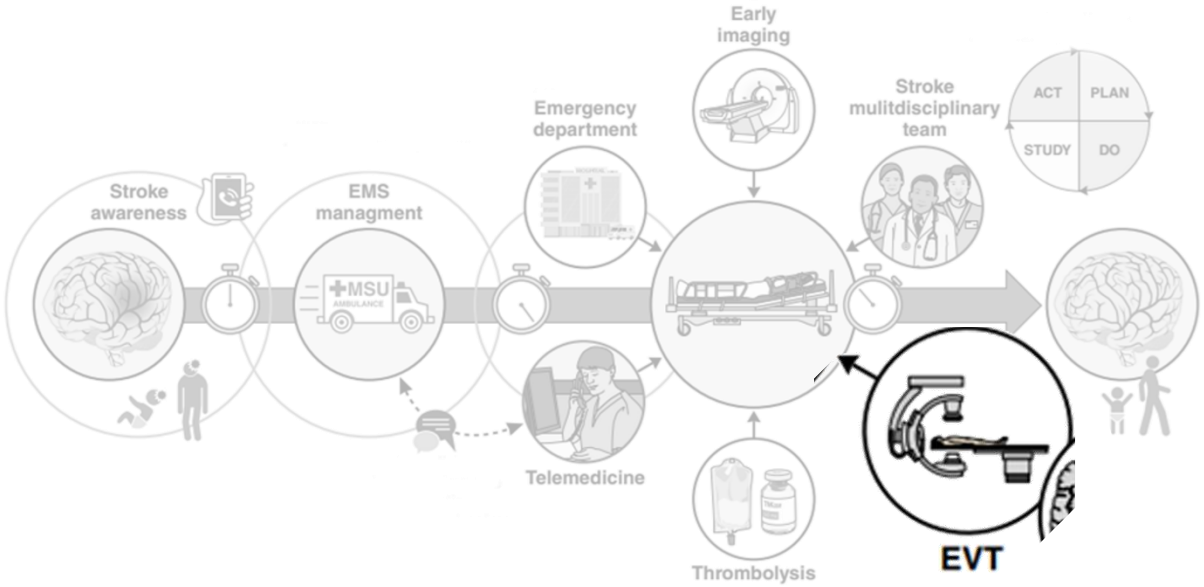
ADULT EVT – BASILAR CRITERIA



Section	COR	LOE	RECOMMENDATIONS
4.7.3	1	A	In patients with AIS, with basilar artery occlusion, a baseline mRS score of 0 to 1, NIHSS score ≥10 at presentation, and PC-ASPECTS ≥6 (mild ischemic damage), EVT within 24 hours from onset of symptoms is recommended to achieve better functional outcome and reduce mortality.

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2026 GUIDELINE FOR THE EARLY MANAGEMENT OF PATIENTS WITH AIS

KEY NURSING UPDATES AND REVIEW

Post Acute Recommendations

DUAL ANTIPLATELET TREATMENT FOR MINOR AIS AND HIGH-RISK TIA

Section	COR	LOE	RECOMMENDATIONS
4.8	2a	B-R	In patients with minor (NIHSS score ≤5) noncardioembolic AIS or high-risk TIA (ABCD2 score >4) within 24 to 72 hours from stroke onset, or NIHSS score of 4 to 5 within 24 hours from onset, who did not receive IVT, with presumed atherosclerotic cause (>50% stenosis of intracranial or extracranial stenosis that was likely to have accounted for clinical presentation or acute new infarctions on imaging of presumed large artery atherosclerosis origin), DAPT (clopidogrel and aspirin) for 21 days followed by SAPT is reasonable to reduce the 90-day risk of recurrent stroke.

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DUAL ANTIPLATELET THERAPY FOR MINOR NONCARDIOEMBOLIC AIS AND HIGH-RISK TIA

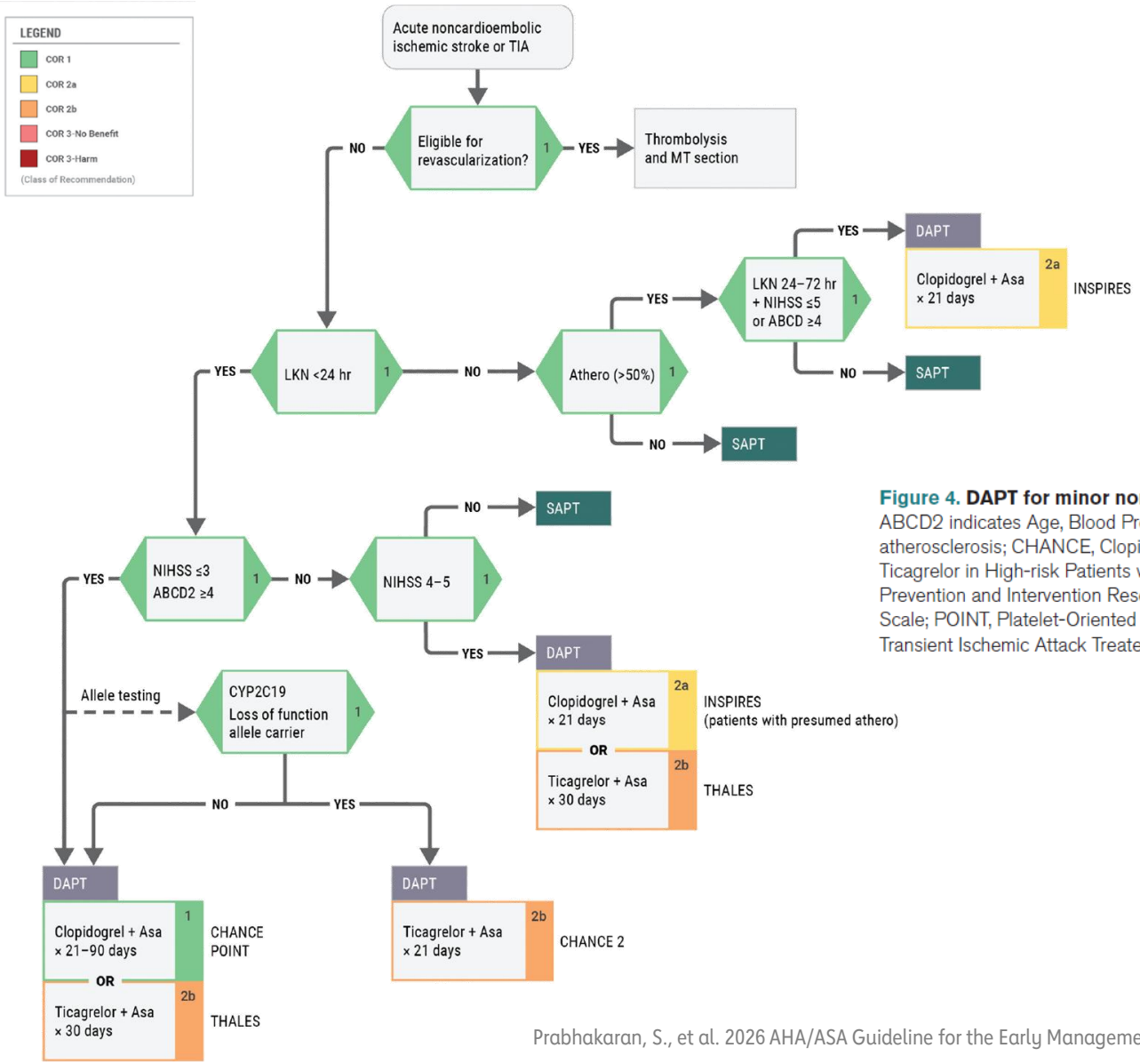

Figure 4. DAPT for minor noncardioembolic AIS and TIA.
ABCD2 indicates Age, Blood Pressure, Clinical Features, Duration, and Diabetes (TIA risk score); AIS, acute ischemic stroke; Asa, aspirin; Athero, atherosclerosis; CHANCE, Clopidogrel in High-risk patients with Acute Nondisabling Cerebrovascular Events; CHANCE 2, Clopidogrel versus Ticagrelor in High-risk Patients with Acute Nondisabling Cerebrovascular Events; DAPT, Dual Antiplatelet Therapy; INSPIRES, Innovative Stroke Prevention and Intervention Research Study; LKN, last known normal; MT, mechanical thrombectomy; NIHSS, National Institutes of Health Stroke Scale; POINT, Platelet-Oriented Inhibition in New TIA and Minor Ischemic Stroke; SAPT, Single Antiplatelet Therapy; THALES, Acute Stroke or Transient Ischemic Attack Treated with Ticagrelor and ASA for Prevention of Stroke and Death; and TIA, transient ischemic attack.

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EARLY ANTICOAGULATION AND ATRIAL FIBRILLATION

Section	COR	LOE	RECOMMENDATIONS
4.9	2a	A	In carefully selected (eg, milder severity) patients with AIS with atrial fibrillation, a strategy of early oral anticoagulation poststroke is low risk and is reasonable compared with a strategy of delayed anticoagulation, although the efficacy of early anticoagulation for prevention of early recurrent stroke is not established.

Source: ACLS Medical Training

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HEAD POSITIONING

Section	COR	LOE	RECOMMENDATIONS
4.2	3 No Benefit	B-R	In patients with AIS, there is no benefit of 0-degree head positioning compared with 30 degrees for 24 hours, to improve functional outcome.
4.2	3 No Benefit	B-R	In patients with AIS with probable large artery atherosclerosis etiology for whom no reperfusion intervention is available, there is no benefit of routine Trendelenburg positioning (-20 degrees) compared with 0- to-30 degree head positioning to improve functional outcome.

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BRAIN SWELLING

Section	COR	LOE	RECOMMENDATIONS
6.1	1	C-EO	In patients with large cerebral or cerebellar infarctions, close monitoring of the patient for signs of neurological worsening during the first days after stroke is recommended to rapidly evaluate the need for potential interventions.
6.1	1	C-EO	In patients with large cerebral or cerebellar infarctions who are at increased risk for malignant brain swelling, early transfer to an institution with appropriate neurosurgical and critical care expertise is recommended to ensure timely treatment.
6.2	3 Harm	C-LD	In patients with large cerebral or cerebellar infarctions and brain swelling, hypothermia, barbiturates, or corticosteroids should not be administered to treat brain swelling due to the lack of evidence of efficacy and potential of increased adverse effects.
6.2	3 No Benefit	B-R	In patients with large hemispheric infarction aged 18 to 70 years, the use of IV glibenclamide does not result in improved functional outcome and is not recommended.

Right MCA stroke with cerebral edema and midline shift.
Hsu C, Subfalcine herniation from complete MCA infarct, complicated by ACA infarct. Case study, Radiopaedia.org https://doi.org/10.53347/rID-19973

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2026 GUIDELINE FOR THE EARLY MANAGEMENT OF PATIENTS WITH AIS

KEY NURSING UPDATES AND REVIEW

General Supportive Care Recommendations

BLOOD GLUCOSE MONITORING

Section	COR	LOE	RECOMMENDATIONS
4.5	1	C-LD	In patients with AIS, hypoglycemia (blood glucose <60 mg/dL) should be treated to avoid complications.
4.5	2a	C-LD	In patients with AIS, it is reasonable to treat persistent hyperglycemia to achieve blood glucose levels in a range of 140 to 180 mg/dL with close monitoring to prevent worse functional outcomes.
4.5	3 No Benefit	A	In hospitalized patients with AIS with hyperglycemia, treatment with IV insulin to achieve blood glucose levels in the range of 80 to 130 mg/dL is not recommended to improve 3-month functional outcomes.

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DEPRESSION

Section	COR	LOE	RECOMMENDATIONS
5.5	1	B-NR	In patients with AIS, administration of a structured depression inventory is recommended to routinely screen for poststroke depression (PSD), although the optimal timing of screening is uncertain.[1-4]
5.5	1	B-NR	In patients diagnosed with PSD, treatment with antidepressants and/or nonpharmacological interventions (ie, psychotherapy, noninvasive brain stimulation, acupuncture) is recommended to improve depressive symptoms.[5-17]

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NUTRITION

Section	COR	LOE	RECOMMENDATIONS
5.3	1	B-R	In patients with AIS, enteral diet should be started within 7 days of admission after an AIS.
5.3	1	B-NR	In patients with AIS, nutritional screening is recommended to direct nutritional management early into hospitalization, preferably within 48 hours of admission, with a nutritional screening or assessment tool that has been validated in patients with acute stroke.
5.3	2a	B-NR	In patients with AIS with dysphagia, it is reasonable to use nasogastric tubes initially for feeding within the first 7 days and to place percutaneous gastrostomy tubes in patients with longer anticipated persistent inability to swallow safely (>2–3 weeks).

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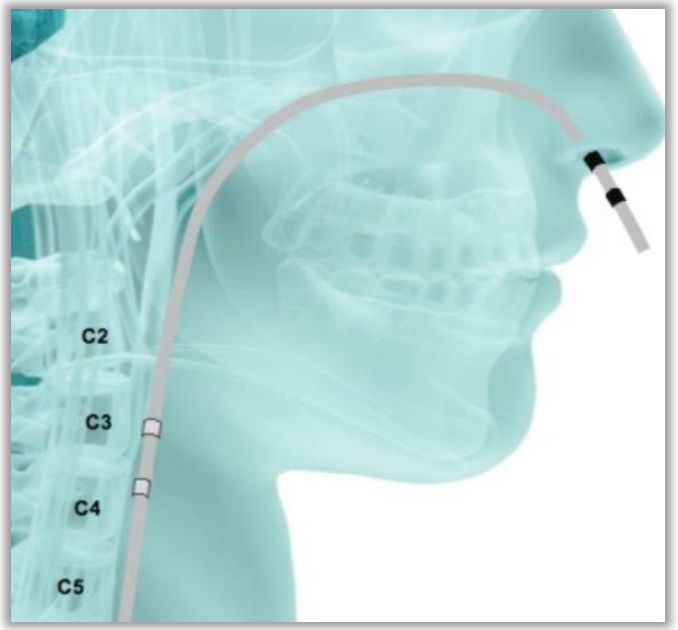
DYSPHAGIA

Section	COR	LOE	RECOMMENDATIONS
5.2	2a	B-R	In patients with stroke with dysphagia, treatment with pharyngeal electrical stimulation (PES), can be beneficial to reduce dysphagia severity and decrease the risk of aspiration.



Restivo, Domenico & Hamdy, Shaheen. (2018). Pharyngeal electrical stimulation device for the treatment of neurogenic dysphagia: technology update. Medical Devices: Evidence and Research. 11. 21-26. 10.2147/MDER.S122287.

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EARLY MOBILIZATION

Section	COR	LOE	RECOMMENDATIONS
5.7	3 Harm	B-R	In patients with AIS, high-dose, very early mobilization within 24 hours of stroke onset is not recommended to improve the odds of a favorable outcome at 3 months and may be harmful.

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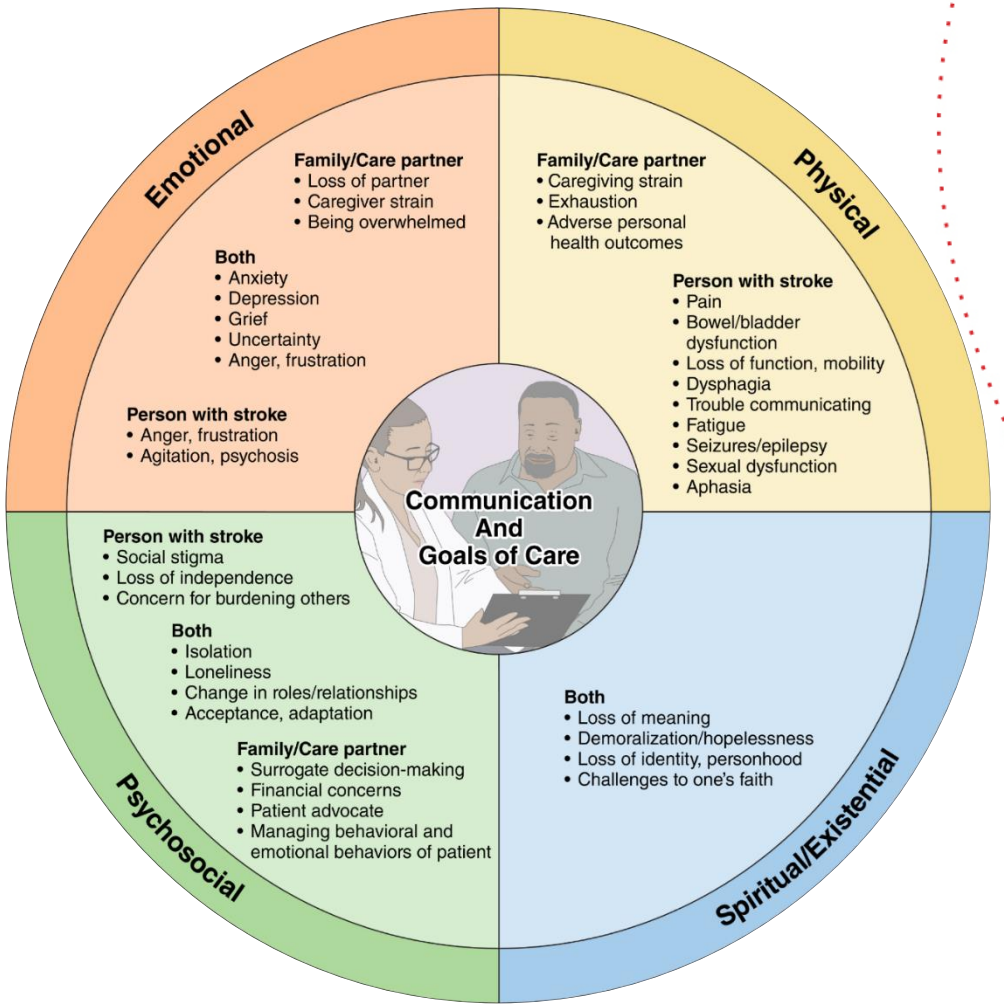
PALLIATIVE CARE

Section	COR	LOE	RECOMMENDATIONS
5.6	2a	C-EO	For select patients with AIS and their families, referral to palliative care resources is reasonable as appropriate.



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MULTIDISCIPLINARY MANAGEMENT

Assessment & Monitoring

- Assessment of stroke diagnosis/mechanism by specialized stroke provider
- Assessment and monitoring by nurses with continuous specialized training in stroke
- Stroke mechanism treatment planning

Clinical Management (First 5 days)

- Standardized acute stroke care order sets utilization
- Physical and medical complications management guided by clinical practice guidelines/protocols
- Early rehabilitation assessment and mobilization by the stroke team
- Multidisciplinary team care to include nursing and caregivers with weekly meetings

Rehabilitation

- Early goal setting and onset of rehabilitation by physical, occupational, and speech therapy
- Integration with specialized rehabilitation nursing care and caregivers
- Collaborative planning with interdisciplinary clinical team

Discharge Planning

- Early assessment of discharge needs
- Integration of patient and caregivers with a focus on continued education support
- Coordination of follow-up care

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